Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a risk based inspection of Cork child protection and welfare services

Name of service area:	Cork
Name of provider:	Tusla
Type of inspection:	Risk Based
Date of inspection:	14 – 17 January 2020
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Niamh Greevy, Erin Byrne, Susan Talbot

About monitoring of child protection and welfare services

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children and Youth Affairs under section 8(1)(c) of the Health Act 2007, to monitor the quality of service provided by the Child and Family Agency to protect children and to promote the welfare of children.

The Authority monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

In order to promote quality and improve safety in the provision of child protection and welfare services, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

The Authority inspects services to see if the National Standards are met. Inspections can be announced or unannounced. This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

How we inspect

As part of this inspection, inspectors met with social work managers and staff. Inspectors observed practices and reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager, three principal social workers and three child protection conference chairs
- focus groups with social workers and social work team leaders
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review children's case files
- observing a child protection conference.

The aim of the inspection was to assess compliance with national standards related to children who have been assessed at ongoing risk of significant harm and are in the child protection conference process/ child protection notification system (CPNS).

Acknowledgements
The Authority wishes to thank children and families that spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

Profile of the child protection and welfare service

The Child and Family Agency
Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team.

Child protection and welfare services are inspected by HIQA in each of the 17 service areas.

Service area
The Cork service area is one of 17 service areas in the Child and Family Agency. Geographically, it is the largest county in Ireland with significant urban population (second largest in the country) and rural spread.

Census figures (2016) show that the overall population for the area was 542,868, representing 11% of the national population. Based on the 2016 census, Cork city grew by 5.4% and Cork County by 4.4% from the 2011 census. The total child population of Cork is 134,015 (24.6%) representing 45% of the South region total child population and 11% of the national child population. It is the highest child populated area in the Child and Family Agency.

The child protection conferencing service was delivered by three principal social workers (PSWs) and administration staff had been employed to assist in the delivery of service. The social work service was delivered through four offices throughout the Cork service area, each based in the locations of Skibbereen, Mallow, Blackpool- covering north of the river Lee and St Finbars Hospital- covering south of the river Lee.

In each child protection and welfare service office, there were teams of social workers that reported to team leaders who in turn reported to principal social workers. Some teams also included childcare leaders and family support workers. There were administrative staff based in each office. The area was under the direction of the service director for the Southern Region.

At the time of the inspection, there were 105 children whose names were entered onto the child protection notification system and who were subject to a child protection safety plan.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant or moderate non-compliant or major non-compliant** with the standards. These are defined as follows:

Compliant	Substantially compliant	Moderate non-compliant	Major non-compliant
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.	The service is not compliant with the standard. Where the non-compliance (moderate) does not pose a significant risk to the safety, health and welfare to children using the service, the provider must take action *within a reasonable time frame* to come into compliance.	The service is not compliant with the standard. Where the non-compliance poses a significant risk (major non-compliance) to the safety, health and welfare of children using the service the provider responds to these risks in a timely and comprehensive manner.

In order to summarise inspection findings and to describe how well a service is doing, standards are grouped and reported under two dimensions:

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

The quality and safety dimension relates to standards that govern how services should interact with children and ensure their safety. The standards include consideration of communication, safeguarding and responsiveness and look to ensure that children are safe and supported throughout their engagement with the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role

14 January 2020	09:30 – 17:30	Ruadhan Hogan Niamh Greevy Erin Byrne Susan Talbot	Inspector Inspector Inspector Inspector
15 January 2020	09:00 – 17:30	Ruadhan Hogan Niamh Greevy Erin Byrne Susan Talbot	Inspector Inspector Inspector Inspector
16 January 2020	09:00 – 16:30	Ruadhan Hogan Niamh Greevy Erin Byrne Susan Talbot	Inspector Inspector Inspector Inspector

Capacity and capability

In September 2019, HIQA received a copy of a local review which was undertaken by the Cork Service Area, in response to a serious incident relating to a child on the Child Protection Notification System (CPNS). Following a review of that report, HIQA sought assurances from the Cork service area manager in relation to all children on the CPNS. The response received did not provide satisfactory assurances and as a result, HIQA undertook an inspection of the Cork service area.

The focus of this inspection was on children placed on the CPNS who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. Children on the CPNS have been assessed as being at on-going risk of significant harm. Inspectors primarily reviewed cases and governance arrangements in two of the four social work offices; the north and south Lee social work offices.

The service area had clearly defined roles and responsibilities for managing children who were subject to a multi-disciplinary case conference (CPC). When children were assessed as being at on-going significant risk, their social worker requested that a multi-disciplinary child protection conference would be held. The child protection chairpersons were responsible for reviewing these and approving where appropriate that a CPC would be held. The scheduling, organising and facilitation of CPCs was delegated by the area manager to the Child Protection chairpersons, while the social worker and their respective managers were responsible for the case management, including the implementation and monitoring of the child protection safety plans. All of these staff ultimately were accountable to the area manager of the service area.

The area manager told inspectors that the delivery of the child protection and welfare service faced significant challenges. He said that there were challenges: in securing legal orders for children, implementing the Tusla national approach to practice to ensure children were safe, and delays in replacing social workers and social work team leaders who had left their jobs.

The governance arrangements in place for the management of children who were subject to a multi-disciplinary case conference and on the CPNS required significant improvement. The area manager had some systems of oversight of the child protection conferencing service in place, but these were not sufficiently robust. The area manager primarily depended on governance meetings, informal communication (telephone calls and conversations), and through the group supervision of principal social workers and case conference chairs. Additionally, individual supervision had

been requested by one of the PSWs and occurred regularly.

Governance meetings were ineffective at providing assurance on the service provided to children on the CPNS. Monthly area governance meetings were held where the entire Tusla Cork service was discussed; discussion relating to children on the CPNS took up a small proportion of that meeting. Quarterly CPNS governance meetings were also held and attended by the CPC chairpersons, the area manager and representatives from the social work teams. Records showed that these meetings primarily addressed procedural matters, for example the format of reports and did not provide oversight and assurance on the service provided. Additionally, the national child care information system (NCCIS) had limited functionality to provide reports on children on the CPNS.

While annual reports were produced that identified trends or patterns for children on the CPNS, there was no system in place to provide assurance to the area manager for children on the CPNS. For example, to determine if they were subject to multiple reviews, a pattern of being active on the CPNS over time or to ensure that all necessary actions were taken in a timely and effective manner to support the provision of an appropriate service to meet their individual needs.

A sample of 5 of 18 cases of children on the CPNS reviewed by inspectors, had been listed for between one and half years and three years. These children had 4 to 6 consecutive CPCs. In four out of five of these cases, there was a lack of timely progress in addressing child protection concerns. Three cases did not have regular social work visits or safety planning meetings. In one of these cases, HIQA escalated the case to the area manager for him to set out how he was assured on the safety of the children. A satisfactory response was subsequently received where HIQA were assured that appropriate decisions were taken on the next steps.

At the time of inspection fieldwork, there were no forums in place in the Cork Service Area, such as a complex case forum, for the area manager to satisfy himself that cases were subject to objective review and reciprocal actions were taken. The area manager informed inspectors that a complex case forum had been established as part of the measures to address the findings of this inspection.

Group supervision that the area manager carried out with the PSWs was ineffective at providing assurance on the effectiveness of service delivery for all children on the CPNS. A review of supervision records of the PSWs showed there was a limited focus on children on the CPNS and they were not consistently discussed. Hence, reporting arrangements for these children was weak.

Inspectors found the quality of social work supervision on individual cases was mixed

and lacked sufficient rigour. For example, inspectors reviewed a case where a social work team leader highlighted the positive engagement of parents with child protection safety plans despite inspectors finding evidence of a lack of parental engagement with the service. During interviews with inspectors, the area manager acknowledged that the quality of recording of supervision required improvement to provide a focus on what actions were undertaken, and what progress has been made since the previous supervision. This was significant as the area manager relied on the quality of social work supervision undertaken by social work team leaders and principal social workers to provide him with assurances on the safety and quality of the service. Social workers told inspectors that they received regular individual and group supervision, but said that if caseloads were smaller, they would have more time to interact and form relationships with families and would be able to fulfil what was required of them.

Two serious incident reviews undertaken in the area were inadequate. HIQA was of the view that they did not contain good quality analysis of the specific situations, and there were limited learnings identified. These were missed opportunities for the service, as learnings from more comprehensive reviews, if implemented, could have positively impact on current practice. As stated, the receipt of these reviews and subsequent unsatisfactory assurances from the area manager were the reason that a risk based inspection was undertaken. It was also of concern to inspectors that the review reports were shared with PSWs and social work team leaders and only the recommendations of the reviews were shared with the child protection conference chairs. In addition, social workers were not provided with the outcome of these reviews at the time of the inspection.

The social work teams within the Cork service area did not carry out any formal quality assurance auditing of children on the CPNS. The area had been subject of quality assurance reviews from the regional and national quality assurance teams during 2019.

In May 2019, the Tusla quality assurance department undertook a review of approximately 60 cases of children on the CPNS. At the time of the inspection, this report was at a draft stage. The findings and recommendations were to be integrated into a composite regional report which had not yet been finalised. A second quality assurance review, began in September 2019, reviewed approximately 200 cases in the north and south lee social work teams. A first draft was issued to the area on 09 January 2020. These quality assurance reports highlighted that improvements were required in the quality of supervision including the tracking of decision making, safety planning, the oversight and management of complex cases and the timeliness of convening case conferences. By the time of the HIQA inspection on the 14 January 2020, actions to address the recommendations of the Tusla quality assurance reviews

had not been drawn up and implemented. However, after the inspection, these reports had been finalised with actions to address the improvements that were required which were send to HIQA.

Inspectors were informed by the area manager that one case on the CPNS was escalated by the Tusla quality assurance department, at the time of the September 2019 review, to the area manager. HIQA inspectors reviewed that case as part of this inspection and found that the case subsequently had direct managerial oversight from the PSW and area manager. Appropriate action was in progress and hence, HIQA were assured that this case was being managed appropriately.

While many of the findings of the draft Tusla quality assurance reports were in line with the findings of this HIQA inspection, systemic actions to address lack of review of cases on the CPNS, drift in cases and the lack of timely and appropriate action, had not been subsequently addressed.

Risk management, relating to children on the CPNS, was poor. Risks that had been identified did not have measures put in place to mitigate against them. The risk register that inspectors were provided with had one risk entered which related to vacant social work posts and its impact on service delivery. Risks identified in quality assurance reports and serious case reviews were not managed through risk management processes. This was not in line with the Tusla risk management policy. Consequently, there were no plans to address the impact of these identified risks on service delivery. In addition, other risks such as the delay in scheduling or poor quality interagency cooperation between Tusla and the HSE had been escalated by the service area. However, these risk escalations were not effective at resolving the issue.

Inspectors found that working arrangements between the local service area, Tusla regional management, and the Tusla national residential services were not always effective at ensuring good outcomes for children. Two of the cases on the CPNS that were escalated by HIQA had previously been escalated by the Cork service area to Tusla regional management, as there was difficulties in sourcing or agreeing funding for care placements for children whose assessments had deemed they required it. Records showed that staff strongly advocated for placements. Alternative interim measures had been put in place for one of these cases. However, despite the Cork area escalation to Tusla regional management, there was no effective action and two child in the sample reviewed by inspectors remained at risk.

Children on the CPNS are those children who are assessed as being at most risk within a child protection service, therefore services should have strong checks and balances in place to safeguard these children. It is of significant concern to HIQA that

weak governance arrangements, delays in the completion of quality assurance reviews, corresponding delays in implementing improvements, mixed quality case supervision and lack of robust review of complex cases meant that the area manager could not be assured on the quality of service provided to children on the CPNS. Methods of assurance were underdeveloped and as a result there was an inconsistency in the quality of service provided to children on the CPNS.

HIQA sought assurances from Tusla in relation to the governance arrangements in place for children on the CPNS in the Cork Service Area. Subsequently assurances were received from Tusla in regard to the further development and implementation of necessary systems in particular to ensure oversight of children on the CPNS. These included the implementation of a complex case forum to review cases where there are particular complexities, new local quality assurances processes for the review of serious incidences, arrangements for the disseminating of learnings, and an audit of supervision practice. Further assurances were sought from the COO of Tusla by HIQA in relation to the area manager's oversight of principal social workers and chairs of case conferences through group supervision. Assurances were provided that group supervision was one of a range of systems that the area manager had in place to assure himself of the service received by children on the CPNS. Other mechanisms were governance meetings and forums along with regular informal contact that the area manager maintained with principal social workers.

HIQA also sought further assurances from the Tusla COO in relation to two individual children and on the arrangements for all children who fall within the remit of both Tusla and the HSE, to ensure they receive a timely and appropriate service. Follow up steps had been taken in both cases and HIQA was assured in one case. Some assurances were received in regard to the short term plan for the second child, but there remained no inter-agency agreement in relation to long term funding for the child. The COO informed HIQA that there is an ongoing review of the inter agency protocol between Tusla and the HSE which would assist in future decision making where both agencies had responsibility.

Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	**Judgment** **Non-compliant Major**

Governance of children on the CPNS in the area was poor. Inspectors found deficits in formal governance reporting arrangements and supervision. The area manager did not have any robust mechanisms in place to assure himself on the quality of service provided to children on the CPNS and that the service was delivered in line with 'Children First 2017: National Guidelines for the protection and Welfare of Children', national policies and child protection and welfare standards. Risk management was not implemented in line with Tusla policy as risks that had been identified did not have measures put in place to mitigate against them. As a result there was an inconsistency in the quality of service provided to children on the CPNS with some children remaining at risk.

Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	**Judgment** **Non-compliant Major**

The social work teams within the Cork service area did not carry out any formal quality assurance audits. While monitoring systems were in place at a Tusla regional and national level, there was no local robust monitoring system in place to report on the compliance of the service and to provide assurance to the area manager for children on the CPNS. There was a lack of forums such as a complex case forum to provide objective analysis of cases. HIQA was of the view that reviews of serious cases undertaken in the area were inadequate and it was of concern that there were limited learnings identified which were not communicated to all relevant members of the service in order to improve child service provision. Two Tusla quality assurance reviews identified issues in the area. However systemic actions to address the lack of objective review and the lack of timely and appropriate action, had not been addressed at the time of the inspection. Not all risks identified in quality assurance reports and serious case reviews were managed through risk management processes.

Quality and safety

When a referral of a child protection nature met the threshold for a service from Tusla, an initial assessment was to be carried out by a social worker. According to Children First (2017) 'National Guidelines for the Protection and Welfare of Children', if the outcome of the assessment was that a child was at risk of on-going significant harm, then Tusla is required to organise a multi-disciplinary case conference or remove the child to alternative care.

The focus of this inspection, was specifically on those children who were subject of a multi-disciplinary case conference (CPC). This section of the report will follow the process from the request for an initial CPC to the chairing of the CPC, where the initial child protection safety plan is devised if required. The child's name may be placed on the Child Protection Notification System (CPNS) if the professionals attending the conference decide that the child is at on-going risk of significant harm. In order for the implementation of the child protection safety plan, further safety planning meetings and visits to the child by a social worker is required. This inspection reviewed the implementation and delivery of the plan by the child's social worker. Finally, the review of child protection plans at CPC reviews were also sampled. This section of the report will follow this process.

Inspectors found that while cases referred for a child protection conference (CPC) met the threshold for a CPC service, initial CPCs did not take place in a timely manner. Requests for an initial CPC were made by the child's social worker, and, approved and scheduled by the CPC chairs. The area manager was satisfied that all requests for a conference met the threshold as there were no requests for a conference turned down by the CPC chairs. Of the cases reviewed by inspectors, all met the threshold for a CPC. Inspectors found there was a time delay of between three and 12 weeks from when the social work team requested a child protection conference to when the CPC took place, with two thirds of cases sampled taking more than 10 weeks for an initial CPC to be held. Given that there were significant child protection concerns for these children, HIQA was of the view that this was a long and unacceptable delay in scheduling these meetings.

CPCs were comprehensively facilitated by an appropriately trained professional who was not directly involved in the assessment or management of the case. Inspectors observed a CPC review and saw discussions that clearly outlined what the child protections risks were and the impact of these risks on children. CPC records showed that parents were clearly told why children were at risk of significant harm, what needed to change and what would happen if there wasn't change. Interagency discussion was well facilitated and a clear and appropriate decision was reached as to whether a child was to remain on the CPNS or not.

Multidisciplinary participation was facilitated during CPCs. Records of CPC minutes showed that all relevant professionals were invited to CPCs including professionals external to Tusla. The records also indicated if those professionals attended or not and if a report was provided. CPC chairs told inspectors that where there were difficulties with professionals from particular agencies attending, the CPC chairs telephoned the particular professional to obtain their opinion and share the information at the CPC. The CPC chairs also said they frequently changed the time and date of CPCs to ensure the attendance of particular professionals. This showed a flexible approach that encouraged the best possible outcome for children. Where there were patterns of non-engagement from particular agencies, the CPC chairpersons said they brought this to the attention of the area manager.

The service ensured active involvement of children and families in CPCs. Records of CPCs showed that the chair of the conference met with families prior to the conference. Parents were asked for their views and were given every opportunity to fully participate in the CPC as possible. The CPC chairs told inspectors that it was standard practice for general practitioners and public health nurses to be automatically sent copies of CPCs and the child protection safety plans for children under the age of 5 as per Tusla's own policy.

The content of child protection safety plans devised at CPCs were of good quality. The plans consisted of a list of actions, identified during the CPC, that were to be implemented and monitored by the social worker. Overall, actions identified on individual plans were comprehensive and addressed the assessed and identified risks, along with the supports to be provided. For example, the area manager said that innovative programs such as the 'creative community alternatives' had been established and maintained to support children subject to child protection safety plans. He said he had commissioned research to provide evidence that this initiative had stabilised families and prevented children coming into care.

The plans also outlined what safety measures were to be addressed following the CPC, during safety planning meetings; the frequency of which was also specified in some of the plans. Child protection safety plans provided a template of next steps for the social worker to implement in order to ensure children's safety.

The implementation and delivery of the child protection safety plan is the responsibility of the social work teams. There were mixed findings in how these plans were implemented and monitored. According to the Tusla guidelines for CPCs and the CPNS, regular safety planning meetings were to be convened following the CPC, to create a more detailed child protection safety plan, review the safety for the child and monitor the progress in the case. Of the cases reviewed where an initial CPC was undertaken in the 12 months prior to the inspection, some had timely and regular

visits to children and parents to implement safety planning and progress actions soon after the initial CPC was held. Other cases did not have this urgency to implement child protection safety plans. For example, one case had no visits to see the child four months after the initial CPC, no safety planning meetings held, and actions were not progressed. Another case was unallocated for a period of time during which time visits, safety planning meetings and actions were not progressed. Along with the risk to the child that this lack of service provided, it was likely that these cases would remain in the CPC system longer than required. The lack of regular safety planning meetings was a feature of 17 out of 18 cases reviewed and was not in line with the Tusla national guidelines for CPCs and the CPNS.

As a result inspectors found that the quality of safety planning for children on the CPNS widely varied from good to very poor quality. Inspectors reviewed records for evidence of detailed safety planning arrangements which were recorded in different formats that had been made with families. Just two of the 15 cases were judged as having adequate safety planning arrangements. The remaining 13 were not judged to be adequate with little evidence of assessment of parental capacity to keep children safe along with poor monitoring and review of safety planning.

The monitoring of children on the CPNS was poor as social work visits to children was poor. Thirteen out of 18 cases reviewed by inspectors for monitoring of child protection safety plans did not have regular consistent social work visits to the family home. In five of these cases, records showed visits by a child care worker or family support worker to undertake specific pieces of work. The area manager pointed out that the child care workers were integral to the teams, built relationships with children and were under the supervision of SWTLs. However, this was not an adequate substitution for the implementation and oversight of the child protection safety plan by a social worker. Seventeen of these 18 cases also did not have safety planning meetings. Hence, there was little opportunity to implement detailed safety planning and to progress actions.

The expectations of the area manager regarding the implementation and monitoring of children on the CPNS and the actual practice on the ground differed significantly. The area manager outlined to inspectors his expectations of social work practice in regard to the implementation and monitoring of child protection safety plans. He said that he would expect that: regular safety planning meetings were established and reviewed the recommendations of the CPC; regular visits to see children took place, every two weeks by a participant in the safety planning meetings; and that there would be sufficient analysis of the progress made between CPCs. The area manager also said that children on the CPNS should have a focus in every supervision with social workers.

Overall inspectors found that service delivered to children on the CPNS fell short of the expectations of Tusla management and was of poor quality. In total HIQA reviewed 21 cases of children on the CPNS during this inspection, 18 of which were active on the CPNS, three of which were closed. Inspectors sought clarification from the social workers and their managers relating to 12 cases, on the progress of plans to address risks. Social workers told inspectors what steps the social work department intended to take to rectify them, including social work visits to the families the following week.

Of the 21 cases reviewed by HIQA, three were escalated to the area manager, for assurances that appropriate action would be taken to address the risk. Satisfactory assurances were subsequently received in relation to steps taken or plans regarding one of these children. Further assurances were sought in relation to the two other children. The area manager said that finding suitable placements for children who should be in care or who are in care, and required a more suitable placement was a significant challenge. HIQA was provided with satisfactory assurances on the arrangements in place for the second child. While steps had been taken to ensure the safety of the third child, decisions on resourcing for the child's long term planning remained outstanding.

Overall the implementation, delivery and monitoring of child protection plans was not was not in line with: 'Children First 2017: National Guidance for the Protection and Welfare of Children'. This specifically stated that "the allocated social worker will review the progress of the interventions from specialist professionals involved with the family and will revise the assessment of risk accordingly. The allocated social worker will remain in close contact with the child and family, make arrangements for assessments and consult with professionals who see the child regularly."

Inspectors did find examples of good practice where social work teams addressed child protection concerns and ensured children's safety. For example in one case, following an initial assessment, an initial CPC was held in a timely manner- within three weeks and subsequent review CPCs were held within six months of each other. The child protection safety plans had detailed actions on supports to be provided, and, specified monitoring arrangements, including unannounced home visits by social workers and welfare checks by Gardai. Records showed these visits were undertaken along with referrals to relevant support agencies. Review CPCs measured parental improvements along with the areas that required further work.

Review CPCs were usually held within six to eight months after the previous CPC. Where inspectors found delays in the scheduling of review CPCs, a rational was provided by the social worker. Review CPC records showed that the progress of actions was reviewed during the conference and an appropriate decision was taken as

to whether a child was to remain on the CPNS or not. Records also showed that CPC chairs identified drift in cases, particularly where there had been multiple review CPCs. They communicated their concerns to the relevant PSW. Inspectors also reviewed cases where children were removed from the CPNS and found this was appropriate.

Some critical decisions taken at CPCs were not able to be implemented due to poor quality interagency arrangements between Tusla and the HSE, particularly in circumstances where children had a disability or where children had mental health issues. Records showed there were difficulties in accessing services for children on the CPNS to ensure children received a coordinated service. For example, one of the cases that was escalated by inspectors had been discussed at the joint Tusla HSE forum. At the time of the inspection this did not result in a suitable or timely placement being approved for the child. Despite being escalated by HIQA and subsequent measures taken to ensure the child's safety, there remained a lack of agreement between Tusla and the HSE in relation to the long term funding of the child's care.

Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	**Judgment** **Non-compliant Major**
While CPCs were well facilitated and there was good practice in the involvement of agencies external to Tusla, the implementation, monitoring and subsequent interventions to keep children safe was poor. Social work practice with children and families was not in line with Children First 2017 and the national guidelines for CPCs and the CPNS.	
Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.	**Judgment** **Non-compliant Moderate**
Review CPCs were well facilitated. However, a small but significant number of cases sampled by inspectors were children who remained on the CPNS for periods longer than 18 months. Their cases were subject to a lack of timely action.	
Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.	**Judgment** **Non-compliant Major**

Critical decisions taken at CPCs were not able to be implemented due to poor quality interagency arrangements between Tusla and the HSE. This resulted in children remaining in placements where their safety was compromised. Despite the case being escalated, agreement was still not reached for the on-going resourcing of the child's care.

Compliance Plan

This Compliance Plan has been completed by the Provider and HIQA has not made any amendments to the returned Compliance Plan.

Provider's response to Inspection Report No:	**MON-028413**
Name of Service Area:	Cork
Date of inspection:	14, 15, 16 January 2020
Date of response:	

These requirements set out the actions that should be taken to meet the *National Standards*

Theme 2: Safe and Effective Services
Standard 2.6 **Non-Compliant Major**
The provider is failing to meet the National Standards in the following respect: Initial Child Protection Conferences did not take place in a timely manner. There were mixed findings in how child protection safety plans were implemented and delivered. The quality of safety planning for children on the Child Protection Notification System widely varied from good to very poor quality. The monitoring of children on the Child Protection Notification System was poor as social work visits to children was poor. **Action required:** Under **Standard 2.6** you are required to ensure that: Children who are at risk of harm or neglect have protection plans in place to protect and promote their welfare **Please state the actions you have taken or are planning to take:**

Proposed timescale:	Person responsible:
• **Time lines: Child Protection Conference: There is no mechanism at present for this to be tracked on National Child Care Information System. However, an advanced find has been established to show the number of approved Child Protection Conference requests and the number of Child Protection Conferences held. Q2** • **The quarterly area Child Protection Conference forum will now review timelines for Conferences, trends & categorization. Q2** • **The rationale for any delays in convening a Child Protection Conference will be included in the child's file by the Child Protection Conference Chairs. Immediate implementation**	**Manager Child Care Information Unit** **Child Protection Conference Chairs**
To ensure the quality and on-going monitoring of the Child Protection Safety Plan, the area will undertake that within 2 weeks of a Child Protection Conference being convened, supervision will take place between the Team Leader and Social Worker to plan the implementation of the Child Protection Conference Safety plan. This will include: ❖ **Frequency of Social Work visits to the child in the home** ❖ **Other professional visits to the child** ❖ **Child involvement and participation in the plan** ❖ **Frequency of safety planning meetings** ❖ **How to address the risks** ❖ **Parental capacity to safeguard the child is addressed** **Agreement in relation to monitoring and review of progress and review date will be agreed, this will provide the necessary assurance and on-going monitoring of the Child Protection Safety Plan. Immediate implementation**	**Child Protection Chairs** **Team Leaders and Social workers**
• **The Area has developed a Pro-forma document entitled "Supervision Child Protection Conference Implementation plan" to be inserted as a case note in all activities. Immediate implementation**	**Team leaders & Social Workers**

Standard 2.7

Non-Compliant Moderate

The provider is failing to meet the National Standards in the following respect:

A small but significant number of cases sampled by inspectors were children who remained on the Child Protection Notification System for periods longer than 18 months were subject to drift and a lack of timely action.

Action required:
Under **Standard 2.7** you are required to ensure that:
Children's protection plans and interventions are reviewed in line with requirements in Children First.

Please state the actions you have taken or are planning to take:

Proposed timescale:	Person responsible:
• **A Complex Case Review Forum is being established, Terms of Reference have been finalized and meetings will take place monthly if required and will be chaired by the Area Manager. March 2020**	**Area Manager**
• **An advanced find has been created for Principal Social Workers and Team Leaders to give the list of children on the Child Protection Notification System (note this list may have duplications based on the timelines for listing children) Q2 2020.**	**Area Manager**
• **Once the child is on the Child Protection Notification System for 12 months, the Child Protection Conference Department will notify the Principals Social Workers of this, and the file will be audited using the Cork Area Child Protection Notification System audit form. March 2020**	**Child Protection Conference Chairs**
• **Any child on the Child Protection Notification System for 18 months is highlighted by the Child Protection Chairs to Area Manager and will automatically go to the Complex Case Forum for review. March 2020**	
• **Current practice will continue whereby Team Leaders and Child Protection Chairs will discuss higher risk cases and the necessity for early review of the Child Protection Conference Plan. March 2020**	**Team Leaders & Child Protection Conference Chairs**

Standard 2.9

Non-Compliant Major

The provider is failing to meet the National Standards in the following respect:

Some critical decisions taken at Child Protection Conferences were not able to be implemented due to poor quality interagency arrangements between Tusla and the Health Service Executive.

Action required:

Under **Standard 2.9** you are required to ensure that:
Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.

Please state the actions you have taken or are planning to take:

Proposed timescale:	**Person responsible**:
• **Meetings are held regularly and cases are appropriately escalated as was the situation in the case escalated by HIQA.** • **There are outstanding issue between the two Agencies in respect of the funding of joint cases as set out in the Joint Protocol document, but this matter was escalated and meetings between the DCYA, Tusla and the HSE have been taking place to resolve same and we understand clarity and a directive in respect of this issue is due shortly.** **March 2020**	**Principal Social Workers**

Standard 3.1

Non-Compliant major

The provider is failing to meet the National Standards in the following respect:

There were deficits in formal governance reporting arrangements and the area manager did not have any robust mechanisms in place to assure himself on the quality of service provided to children on the Child Protection Notification System.

Governance meetings were ineffective at providing assurance on the service provided to children on the Child Protection Notification System.

There was no system in place to review children on the Child Protection Notification System to identify trends or patterns for children on the Child Protection Notification System.

The quality of social work supervision on individual cases was mixed and lacked sufficient rigour.

Group Supervision that the Area Manager carried out with the Principal Social Workers was ineffective at providing assurance on the effectiveness of service delivery for all children on the Child Protection Notification System.

Inspectors found that working arrangements between the local service area, Tusla Regional Management and the Tusla National Residential Services were not always effective at ensuring good outcomes for children.

Action required:
Under **Standard 3.1** you are required to ensure that:
The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

Please state the actions you have taken or are planning to take:

Proposed timescale:	Person responsible:
• Formal supervision structures will be maintained between the Child Protection Conference Chairs, Principal Social Workers and the Area Manager. Q 1 2020	Child Protection Conference Chairs & Area Manager.
• As per Tusla's Supervision Policy, front line Social Workers are supervised by Team Leaders. Team Leaders in turn are supervised by the Principal Social Work who are in turn supervised by the Area Manager. Throughout this chain of supervision structure, issues of concern raised by Social Workers are assessed and evaluated by the relevant supervisor and subsequently escalated or referenced to the next level of supervisor as deemed appropriate. Individual cases that are problematic or of serious concern would be escalated to the Area Manager and relevant discussions and decisions would then be taken. There is also a lot of informal supervision through telephone contact and face to face meetings where issues are raised and discussed.	Child Protection Conference Chairs Principal Social Workers Principal Social Workers
• The Area Forum will be used to identify timelines, trends and the catagorising of cases to be appropriately escalated to the Complex Case Forum. Q2 2020	Quality Assurance in consultation with the Area Manager.
• The Cork Area has a Supervision Audit tool and schedule devised for auditing supervision files. A tracker has been developed through which learning arising from the audits can be shared with the management team and relevant recommendations are actioned. Specific issues of concern/themes arising such as the rationale for long term care decisions. Q2 2020	
• Another audit has been devised for children on the CPNS and work is progressing in respect of this action. Q3 2020	
• Issues of concern arising from these audits will be raised as a standing item on the group supervision meetings between the Area Manager and the Child Protection Principals and Case Conference chairpersons, respectively.	
• Where the criteria are met for the calling of a Complex Case Conference Forum meetings are met this will be escalated to the Area Manager and the Forum will be convened asap. Q2 2020	
• Supervision pro-forma as per the Supervision policy will include discussion decisions, actions and review of previous actions. This has been agreed for the North Lee Team since November 2019, this is to be implemented across the Cork area by end of Q2.2020.	
• A Quality Assurance Audit of Supervision has been arranged with Quality and Assurance scheduled to begin audit on 01 May 2020 but this has been put back to Q3/Q4 as a consequence of the COVID 19 pandemic Q3/4	

Standard 3.3

Non-Compliant Major

The provider is failing to meet the National Standards in the following respect:

Serious incident reviews undertaken in the area were inadequate as they did not contain good quality analysis of the specific situations, and learnings were not consistently identified.

There were no forums in place, such as a complex case forum, for the area manager to satisfy himself that cases were subject to objective review and reciprocal actions were taken.

The service area had no local formal quality assurance systems in place within the Cork service area for children on the Child Protection Notification System.

The recommendations of the draft Tusla quality assurance reports including systemic actions to address lack of review, drift in cases and the lack of timely and appropriate action, had not been actioned.
Risk management, relating to children on the Child Protection Notification System, was poorly addressed.

Action required:
Under **Standard 3.3** you are required to ensure that:
The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.

Please state the actions you have taken or are planning to take:

Proposed timescale:	Person responsible:
• **A group has been requested by the Area Manager to put in place Terms of Reference for a system to disseminate the learning from Serious incidents/ National Review Panel annual reports. Area/team presentations will be delivered to enhance the learning for staff. For completion by Q2 2020.** • **Complex case management forum agreed as outlined in Standard2.7** • **Cork Area Child Protection Notification System Audit tool developed and schedule agreed.** • **The DRAFT QA report for Child Protection and Welfare cases which was undertaken in Sept-Nov 2019 was issued on the 9/01/2020 to the Area Manager and Principal Social Workers, and note the HIQA inspection commenced on the 14/01/2020.** • **The CPNS QA Audit undertaken in May 2019 did not make any local recommendations and the Regional report is to our knowledge still awaited.** • **The QA CP&W Action plan was submitted to HIQA by the CEO on 14/02/2020**	**Kieran Campbell Child Care Manager** **Barry Murray Area Manager** **Principal Social Workers**